Dear Your Honor,

CLERK S USTALL

DEPUTY

My name is Britary Gail Ogg. I how a bill with Cody Collections in Cody Wyoming. That also has been turned into your curt room. I hove called them and we have made an agreement of \$100000 a month for my auont of \$14,000 and the other of \$1 987. I am writing to you to confirm with you that you will agree with the payment arrangement Cody Collections and I have made until the remaint is fully paid on full.

Sincerey,

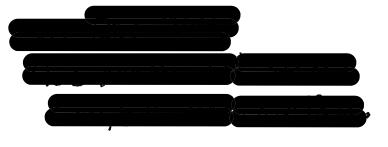
Britary Guil Ogg

Please gue a call with any questions or concerns.

Thankyu

for your

time.



## FILED IN CIRCUIT COURT BIG HORN COUNTY, BASIN, WY

Circuit Court Judge. Supt 3rd-Dear Sir. I'm writting to you about the kill to Three Rivers Hospital. I took my grandson Charles Scott to the emergency Rixm, To be Breeten. They said I meeded to sign him in so the Doctor Can treat him I told them, I would not be responded for the bill on him. He is 20 zers ald, the is working full time, so he can Paython him sey. They said that is fine, but he still has to be checked in Toke treated. I never received any Japan work about me having to Pay. This kill, He is 21 you old now still working, He saw he will get a hord of the hospital and make arrangement to start making Payments, so would you Please remove my name of of this Judgment againstone He lives in Dawaii wood his Mom & step Jather, my daughter onna Ross dais she would make

FILED IN CIRCUIT COURT BIG HORN COUNTY, BASIN, WY D 1202 1. 0. 935

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Patient: SCOTT, CHARLIE Provider: SPROAT, ADAM M. Visit#: 0110685 MR#: 0011269

Version #: 1 Saved By: C O Saved On: 08/07/20 17:15



Phone: 307-568-3311

FILED IN CIRCUIT COURT BIG HORN COUNTY, BASIN, WY

8/7/2020 115

Name:

SCOTT, CHARLIE

DOB:

Age:

21 years old

Sex: Male

## South Big Horn County Hospital District

South Big Horn County Hospital does not discriminate on basis of race, color, national origin, age, sex, creed, or disability in admission or access to, or treat or employment in, its programs and activities.

AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION, AND DIRECT PAYMENT

I hereby authorize South Big Horn County Hospital's licensed professionals to administer or prescribe such treatments as may be necessary. Authorization is also granted for members of the hospital staff to administer such treatments or procedures as ordered by the healthcare professional.

SBCH is authorized to release all or part of the patient's medical record to any person or corporation which is, or may be, liable for any part of the medical services. It is understood that a photocopy of this form is a valid authorization for release.

I authorize direct payment of insurance benefits to South Big Horn County Hospital. I understand I am financially responsible for all charges incurred.

SBCH is hereby released from any responsibility for valuables - monetary, sentimental or personal- which he/she has now, or may aquire, during the period of care.

I understand SBCH provides electronic access to visit information through a secure patient portal and this information is only retrievable by myself or an authorized representative. Instructions for accessing this information will be provided with discharge information and upon request.

I acknowledge that I have received the SBCH Privacy Notice and any questions I may have may be addressed to the Privacy Officer.

Patient or Legal Guardian Signature: Time of Signature: Date: 1715 8/7/2020 15 Time of Signature: Date: Hospital Representative Signature Electronically signed by OLIN, CAROLYN on 08/07/20 17:15 hrs Select a date 115